Leighton Farm, LLC and Thoroughbred Placement Resources, Inc. Release Form

Must be signed and on file each year and be current for every visit. Click print on your browser.

NOTICE

You are hereby notified that any equine activity is dangerous AND may result in injury or death AND that there are a number of INTRINSIC DANGERS in equine activities which you agree to assume by your (or your parent or guardian if you are under eighteen) signing this waiver of your rights to sue and assumption of danger. These dangers include, but are not limited to the following:

(1) the propensity of an equine to behave in dangerous ways which may result in injury to the participant.

(2) the inability to predict an equine's reaction to sound, movements, objects, persons or animals.

(3) Hazards of surface or subsurface conditions.

WAIVER OF RIGHT TO SUE, ASSUMPTION OF INTRINSIC DANGERS/RISKS AND INDEMNITY AGREEMENT

In consideration for and as a condition to my/our being allowed to participate in :

_____

at Leighton Farm and Thoroughbred Placement Resources, Inc.
on_____- and in the future until this waiver and assumption of danger/risk is specifically revoked in writing by the undersigned (or his or her parent or guardian if under the age of eighteen) the undersigned acknowledges the above notice and accepts that there are intrinsic dangers in owning and/or riding horses, participating in, assisting in and the participation in and observing of equestrian events, competitions and activities.

NEVERTHELESS, the undersigned participant (and parent or guardian if participant is under the age of 18)in equine activities at LEIGHTON FARM AND THOROUGHBRED PLACEMENT RESOURCES, INC. hereby RELEASES and WAIVES his or her right to sue Kimberly Godwin Clark, trading as LEIGHTON FARM AND THOROUGHBRED PLACEMENT RESOURCES, INC., her agents, her employees, AND any other equine professional and equine activity sponsor, organizer, organizing committee. judge or official, their officers, agents, employees and volunteers, for any and all claims for loss, damage and/or injury to me and my property (including but not limited to, motor vehicles, trailer, tack, horse and equipment) however caused and at any time occurring, resulting from, arising out of or during the course of, or in any way connected with the aforesaid equine activity.

I/we undertake to enter or have our horses entered in this equine activity at my/our own risk.

This Agreement shall be so construed as to provide to the sponsor/professional the fullest protection of a release , waiver or right to sue and assumption of all intrinsic dangers which is afforded to the sponsor/professional by the Act and by general law.

FURTHER , I/We hereby agree in further consideration for and as a condition of my/our being allowed to participate in the aforesaid equine activity, hereby agree to indemnify, save, and hold harmless Kimberly Godwin Clark, trading as LEIGHTON FARM AND THOROUGHBRED PLACEMENT RESOURCES, INC., her agents and employees, and any other equine professional and equine activity sponsor, organizer, organizing committee, from any and all claims for loss, damage, and/or injury to any third party, their person and/or property, including the costs of legal defense of any such claim however occurring, resulting from, arising out of or during the course of, or in any way connected with my/our riding in or participating in the above equine activity.

Given under my/our hands this_____ day of _____ 20____

_____

Participant (rider)

Participants Date of Birth _____/_____/_____

_____

Owner of horse & emergency phone

_____

Parent or Guardian

MEDICAL AND LIABILITY RELEASE

(Please print with blue or black ink only)

NAME _____

[ ] Male [ ] Female AGE _____ DATE OF BIRTH_____

CITY _____ STATE_____ ZIP _____

HOME PHONE (_____)_____ CELL PHONE (____)_____

PARENT'S EMAIL: _____

STUDENT'S EMAIL: _____

EMERGENCY CONTACT #1 _____ PHONE (____)_____

EMERGENCY CONTACT #2 _____ PHONE (____)_____

FAMILY DOCTOR _____PHONE (____)_____

HEALTH HISTORY:

_____Drug Allergies_____
_____Heart Condition
_____Behavior/Nervous Disorder
_____Food Allergies _____
_____Asthma
_____Physical Handicap

_____Environmental Allergies_____
_____Seizure Disorder
_____Stomach Problems
_____Insect Stings_____
_____Diabetes
_____Other_____

If any of the above are checked, please give details (i.e. include normal treatment of allergic reactions)

_____

_____

_____

Date of last tetanus shot:_____

Name, dosage, and frequency of any medications that must be taken regularly, or as needed:

_____

_____

_____

Do you have Health Insurance? Yes____ No____

Name of Insurance Company_____

Insurance Company Address _____

Policy Number_____

MEDICAL RELEASE:

In the event I am unconcious or unable to communicate, I hereby give my permission to the physician or dentist selected by Thoroughbred Placement Resources to hospitalize, to secure proper treatment as deemed necessary. The signature below is intended to serve as a medical release.

Signature _____

Print Name _____

Spouse's Name_____ **Date** _____

Patient Information (PLEASE PRINT)

PATIENT NAME Last First Middle Initial Date of Birth Age Sex

Social Security No. Race Marital Status Mother's Maiden Name Drivers License No. Birthplace

PATIENT ADDRESS City State Zip Code

Area Code/Home Phone No. Area Code/Work Phone No.

Church Religion Primary Language

Patient's Employer Occupation Employer's Address City State Zip Code Length of Employment

SPOUSE OR NEAREST RELATIVE Relation to Patient Address City State Zip Code

Area Code/Home Phone No. Area Code/Work Phone No.

Spouse or Nearest Relative Employer Employer's Address City State Zip Code Length of Employment

Insurance Information (PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD)

Primary Insurance Company/Medical Group Address City State Zip Code Area Code/Phone No.

Subscriber Name Date of Birth ID/Social Security No. Group No. Primary Physician Name Effective Date

Secondary Insurance/Medical Group Address City State Zip Code Area Code/Phone No.

Subscriber Name Date of Birth ID/Social Security No. Group No. Primary Physician Name Effective Date

Medical Information

Attending Physician

Obstetrical Patient Due Date